UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SUBOXONE / SUBUTEX

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Minimum age requirement: 16 years old.
- Documented diagnosis of opioid dependence
- Rule out concomitant use of long-acting opioids or maintenance therapy with short-acting opioids.
- Prescribing physician must have an X-DEA number.

AUTHORIZATION:

One 8-week taper schedule.

RE-AUTHORIZATION:

Same as initial request.

10/1/9